Rhode Island AIDS Drug Assistance Program
FINANCIAL Enrollment Form

Do not write in this box →		Insurance

Instructions:

- Enroll with a case manager at a RI Department of Health-funded community-based organization.
- Review *RI ADAP Client Agreement Statement* provided by your case manager.
- With your case manager, answer all of the questions on the *Financial Enrollment Form* (pages 1-3). Both you and your case manager must sign and date this form.
- Ask your medical doctor to complete and sign the *Medical Enrollment Form* (pg. 4)
- Submit both forms at the same time (*Financial* and *Medical*) along with proof of income and residency, and copies of any health coverage/insurance cards.

Demographic Information

Last Name	**First Name**	**MI**

Street Address* (Mailing Address)	**City**	**Zip**

Telephone	**Social Security #**
( ) _____ – _____	___ ___ ___ – ___ ___ – ___ ___ ___ ___

Contacting You

☐ Yes ☐ No Can we leave confidential message at this phone number?

☐ Yes ☐ No Would you prefer that future recertification applications be sent to your case manager?

Date of Birth	**Gender**
___ ___ / ___ ___ / ___ ___	☐ Male ☐ Female ☐ Transgender

Sexual Orientation

☐ Gay man ☐ Lesbian ☐ Heterosexual ☐ Bisexual ☐ Other

Marital Status (Relationship Status)

☐ Married ☐ Domestic Partner ☐ Single/Never Married ☐ Divorced or Separated ☐ Widowed

Ethnicity (please check one)	**Race**		
☐ Hispanic/Latino(a)	☐ White	☐ Native Hawaiian/Pacific Islander	☐ Other
☐ Not Hispanic/Latino(a)	☐ Black	☐ American Indian/Alaska Native	_____
Please also complete race →	☐ Asian	☐ More than one race	

Country of Birth	**Preferred Spoken Language**
_____	_____

HIV Transmission

How did you contract HIV?

☐ Male to male sex ☐ Heterosexual sex ☐ Other

☐ IV drug use ☐ Do not know _____

***Remember to attach proof of RI residency. This can include a copy of a driver's license, utility bill, or rental agreement. The address on the document should match the address above. If no permanent residence, your case manager can provide a letter documenting your current address.**

Case Manager

Name	**Organization**

Address	**City, State, Zip**

Phone	**Fax**	**E-mail Address**
( ) _____ – _____	( ) _____ – _____	

Case Manager's Signature

_____ **Date** _____

Return this completed form by mail or fax to:

RI Dept. of Health, Office of HIV/AIDS & Viral Hepatitis
3 Capitol Hill, Room 106
Providence, RI 02908

Tel: 401.222.7548
Fax: 401.222.7620
www.health.ri.gov

Financial Information

Your gross annual income*	Dependents	Housing Status
$	_____ (#)	☐ Permanent (rent or own) ☐ Temporary (shelter, family/friends, facility) ☐ Homeless
Total Liquid Assets**(see definition and exclusions below) $		

Employment

Are you currently employed? ☐ Yes ☐ No

***Gross income** means total income before taxes and deductions. Your income includes all earnings and support, including SSDI, SSI, unemployment compensation, and other benefits, as well as income from a legal spouse. Remember to attach proof of income such as a copy of your most recent pay stub (showing period covered by the check), or a tax return or W-2 form for the most recent tax year. If self-employed, include a copy of your most recent federal tax return or 1099 form. If you have no earnings, please include a letter from your case manager stating that you have no income and describing how you are being supported.

****Liquid assets** include any savings, checking, or money market accounts, stocks/bonds, investments, or other easily convertible assets **EXCEPT** for your primary residence and automobile.

Insurance/Health Care Coverage

Please indicate whether your health care is paid for by any of the following programs. If yes, provide your ID or Card # and/or name of insurer/carrier. If no, indicate if you have applied and when (if applicable).

Medicaid/Medical Assistance	☐ Yes ☐ No ID/Card # _____ ☐ Managed Care? ☐ HMO?	If no, have you applied? ☐ Yes ☐ No Date applied: _____
Medicare	☐ Yes ☐ No ID/Card # _____	If no, have you applied? ☐ Yes ☐ No Date applied: _____
Medicare Part D (Pharmacy Benefit)	☐ Yes ☐ No ID/Card # _____ Plan Name _____	If no, have you applied? ☐ Yes ☐ No Date applied: _____
RIte Care	☐ Yes ☐ No ID/Card # _____	If no, have you applied? ☐ Yes ☐ No Date applied: _____
GPA	☐ Yes ☐ No ID/Card # _____	If no, have you applied? ☐ Yes ☐ No Date applied: _____
Private Insurance	☐ Yes ☐ No ID/Card # _____ → Insurers Name:	Does your prescription benefit require you to use a mail order pharmacy? ☐ Yes ☐ No
Veterans Administration (VA)	☐ Yes ☐ No ID/Card # _____	If no, have you applied? ☐ Yes ☐ No Date applied: _____
Other Public Assistance (specify) _____	☐ Yes ☐ No ID/Card # _____	If no, have you applied? ☐ Yes ☐ No Date applied: _____

Is AIDS Project RI helping you with **COBRA/Health Insurance** payments? ☐ Yes ☐ No

***Remember to attach a copy of your insurance card for any of the programs above in which you participate. Insurance information and a copy of your card are REQUIRED for enrollment.**

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Pharmacy*

Store Name	Phone	Do not write in this space
	( ) _____ – _____	☐ Pharmacy contacted Date: _____
Address		

***Pharmacy information is REQUIRED. Without it, we cannot contact the pharmacy and enroll you in the program.**

Client Certification and Signature

I fully understand that by applying for this program, I am divulging personal information that will be used to assist the Rhode Island Department of Health in providing me with benefits associated with the RI AIDS Drug Assistance Program. I understand this information will be kept confidential (*§ 23-6-17 Confidentiality, § 23-6-18 Protection of records*), but will be used by staff to review my eligibility for this program. Also, by signing this form, I understand that the information contained within may be used to verify HIV status, receive information from my physician about my care, or obtain other necessary information to provide me with these benefits. By applying for this program I fully understand that this does not mean that my application will be accepted, as funds are limited and eligibility requirements must be met. In addition, I understand Rhode Island Department of Health reserves the right to terminate benefits due to a lack of funds and/or fraudulent claims on behalf of an applicant. I also understand that this program is a payer of last resort, meaning that I must exhaust all other possible sources of payment for these services before applying for this program. Lastly, I understand that it is my responsibility to provide Rhode Island Department of Health with truthful information and documentation about my financial, employment, insurance, and HIV status.

I certify that the information provided in this application is true and correct as of the date below and acknowledge that any intentional or negligent misrepresentation of the information may result in nullification of this application and liability for money granted.

1. **It is my responsibility to re-apply (recertify) with ADAP every 6 months on or before my birth date and 6 months following. If I do not recertify, my ADAP benefits may be terminated.**

2. **I agree that to be eligible for ADAP benefits, I must have a case manager at a RI Department of Health-funded community based organization.**

Lastly, I certify that I have received and agree to all the terms in the **RI ADAP Client Agreement Statement**.

Signature _____ **Date**_____

Print Name _____

Checklist

Please submit all required forms and documents at one time via fax or mail to the address at the bottom of the page. Incomplete applications will delay your enrollment in and access to this program.

Did you remember to:

- ☐ Attach proof of Rhode Island residency? (copy of lease, utility bill with address, drivers license, etc.)?
- ☐ Attach proof of income (e.g., copy of pay stub, assistance checks, or tax forms)?
- ☐ Include a completed *Medical Enrollment Form* (next page) signed by your provider/physician?
- ☐ Attach copy(-ies) of any health insurance or benefits cards?
- ☐ Include your case manager's signature on page 1?
- ☐ Sign the client agreement above?

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Rhode Island AIDS Drug Assistance Program
MEDICAL Enrollment Form

Do not write in this box → **Client Code**

Instructions

- This form is to be completed by the client's **Medical Provider.**
- Please print clearly and provide all requested information**.**
- Sign form and return to client.
- Client -- Return this form together with the Financial Enrollment Form and all required documentation.

Client Name Last First MI		**Date of Birth** ___ ___ / ___ ___ / ___ ___ month day year
HIV Approximate date of first positive HIV test:	**Date** ___ ___ / ___ ___ / ___ ___ month day year	
AIDS Diagnosis ☐ Yes ☐ No If yes, date of diagnosis:	**Date** ___ ___ / ___ ___ / ___ ___ month day year	
HCV Test ☐ Yes ☐ No If yes, date of test:	**Date** ___ ___ / ___ ___ / ___ ___ month day year	**HCV Diagnosis (if tested)** ☐ Negative ☐ Positive
General HIV Medical Care Visit Previous 6 months ☐ Yes ☐ No Date of last test: *(Please provide date for both Yes or No response)*	**Date of Last General HIV Medical Care Visit** ___ ___ / ___ ___ / ___ ___ month day year	
CD4 Count Count: _____	**Date of Last CD4 Test** ___ ___ / ___ ___ / ___ ___ month day year	
Viral Load (Most Recent) Load: _____	**Date of Last Viral Load Test** ___ ___ / ___ ___ / ___ ___ month day year	**Test Type** (bDNA, RT-PCR)
Drug Therapy ☐ No HAART medications ☐ _____ (#) Antiretrovirals currently ☐ HCV Therapy		

Name of Physician (print)_____**RI Lic. #** _____

Signature of Physician _____ **Date** ____ / _____ / _____

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